December 3, 2010

**RE:** Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

Dear Director Hamos and Director McRaith:

Illinois Health Care for America Now (HCAN) is a broad coalition of labor, consumer, and provider organizations that led the grassroots effort to pass the Affordable Care Act and works ensure its implementation. We welcome this opportunity to respond to the Request for Comments regarding the new health insurance Exchanges created by the Affordable Care Act.

The Exchanges will provide affordable, high-quality health insurance options to millions of families and employees of small businesses. A successful Exchange must have in place a process for eligibility determination, active purchasing, adverse selection, transparency, regulating brokers, and certifying QHPs. We are confident that Illinois will lead the way Nationally in the creation and implementation of the Exchange.

On behalf of the organizations within Illinois Health Care for America Now, thank you for making the Exchange a priority and actively moving forward on its implementation.

Sincerely,

John Gaudette
State Director
Illinois Health Care for America Now

Action Now
AFSCME Council 31
AIDS Foundation of Chicago
Amalgamated Transit Union Local 416
Amalgamated Transit Union Local 1733
American Baptist Churches of Metro Chicago
AMSA – Northwestern University Chapter
Chicago Jobs Council
Chicago Jobs with Justice
Citizen Action of Illinois
Chicago Teachers Union
Church Women United in Illinois
Coalition of Black Trade Unionists
Coalition of Labor Union Women of Illinois
Illinois AFL-CIO
Illinois Coalition for Adolescent Health
Illinois NAACP
Illinois Association of Acupuncturists and Oriental Medicine
Illinois Public Interest Research Group (Illinois PIRG)
National Alliance on Mental Health (NAMI) Illinois
National Alliance on Mental Health (NAMI) Barrington Area
Northeastern Illinois Federation of Labor
Northwest Suburban (Chicago) Ch. - National Organization for Women
Planned Parenthood of Illinois
Protestants for the Common Good
Save the Patient
SEIU Illinois Council
Shriver Center of Poverty Law
United Food and Commercial Workers Local 1546
United Church of Christ, Chicago Metro Assocation
Women Employed

## STATE EXCHANGE OPERATIONS

Responsibilities of the Exchange

The Exchange will have to conduct a number of activities that are essential to its success in delivering affordable, high-quality health insurance coverage.

For example, Exchanges must do the following:

- Establish standards for qualified health plans offered in the Exchange, consistent with Section 1557 of the Act;
- Negotiate with and select plans to participate in the Exchange;
- Certify and decertify plans to be offered in the Exchange and exercise the authority to exclude certain plans if it is in the interests of individuals and employers in the state or if a plan proposes unjustified premium increases;
- Monitor marketing practices, ensure benefits are not having the effect of segmenting risk, ensure an adequate choice of providers, and monitor the handling of consumer complaints;
- Administer risk adjustment mechanisms among participating insurers;
- Establish eligibility criteria, consistent with the ACA;
- Establish and oversee the navigator program;
- Determine whether individuals qualify for the federal premium tax credit and the cost-sharing reductions;
- Establish and administer an appeals process for individuals denied eligibility for the tax credit;
- Screen and enroll eligible people for public programs like Medicaid and the Children's Health Insurance Program (CHIP);
- Determine hardship exemptions for individuals and employers to purchase health insurance;
- Determine penalties for employers who drop or don't provide health care for their employees;
- Establish and administer an appeals process for employers challenging penalties;
- Establish policies and procedures for verification of Social Security numbers, tax credit eligibility and immigration status with federal agencies;
- Handle and transmit confidential information, including federal income tax return data, income and other information included in Medicaid applications, and Social Security Administration data; and

Because these decisions will determine such things as whether low- and moderate-income individuals and families obtain the premium-tax credits and cost-sharing reductions to which they are eligible and thus whether they can obtain health coverage, there must be strong process in place for the performance of these functions.

Active Purchaser

An important implementation choice will be whether Exchanges should maximize plan participation by admitting all plans that meet the minimum certification requirements for Qualified Health Plans or use their certification authority to limit Exchange participation to highest-value plans.

The ultimate goal of making affordable health coverage available to individuals and employers can be best achieved by an Exchange acting as an active purchaser and using its authority to only offer plans that enhance value, consumer protection and affordability. Insurers will be adding millions more enrollees through the Exchanges. In return, health plans should be required to achieve a higher level of value for enrollees and for taxpayers that are supplementing the purchase of policies. Active negotiation with insurers will also give them needed leverage to restrain provider payment rates in the face of high provider concentration in many markets. Negotiations should favor plans that promote innovative health-care delivery system reforms that hold promise for slowing the rate of growth in health care costs and should promote a strong foundation of well-coordinated primary and preventive care.

Adverse Selection

The history of insurance pools has taught us that the greatest threat facing Exchanges is adverse selection. A death spiral will ensue if an Exchange becomes essentially a high-risk pool - the Exchange will become unattractive to insurers and coverage will become unaffordable to individuals and employers.

There are several characteristics Exchanges should have to minimize adverse selection:

- State legislation that gives strong and clear direction to Exchange governing boards and managers to create an active and ongoing process to guard against adverse selection.
- Identical regulation of the individual and small group markets inside and outside of the Exchange.
- To extent that any plans are sold outside the Exchange, ensuring that the same plans are available inside and outside the Exchange. For example, Illinois can require insurers outside the Exchange to offer products in the same coverage levels (at least the Silver and Gold levels) as is required for health insurers participating in the Exchange.
- Having a larger Exchange by merging the individual and small group markets, generally will reduce the risk of adverse selection

Transparency

The operation of the Exchange must be as transparent as possible. Such measures should include public meetings, posting evaluations and updates on Exchange performance on the Exchange website, disclosing potential conflicts of interest of members of Exchange governing board or executive staff, and reporting administrative costs for the Exchange. Administrative costs should be itemized in such a way that interested parties can evaluate whether or not expenses improve efficiency (such as more staff time in negotiating with health plans).

Brokers and Distributors

Agents, brokers and distributors are expected to continue to play a role in the newly reformed health care system, but the ACA did not, unfortunately, contemplate specific regulation of these actors. To the extent that agents and brokers play a role in helping small employers and/or individuals consider different insurance plan options, however, their actions could have a

disruptive effect and undermine many of the important provisions of the ACA in the absence of clear rules and standards. For example, if agents and brokers steer healthy, young men and/or small employers comprised of such individuals to certain plans outside of the Exchange – and conversely, steer women of childbearing age and/or employers comprised of such individuals to plans inside the Exchange – this could create adverse selection problems and threaten the long-term viability of the Exchanges.

Illinois must provide oversight and regulation of broker and agent activity to ensure that their actions do not undermine the Exchange and other key provisions and protections of the law. Exchanges should be required to carefully monitor the conduct of insurance agents, brokers and distributors. Regulators should prohibit door-to-door solicitations and bar activities and agent financial incentives and rewards that are designed to steer, discourage or encourage enrollment in particular plans inside or outside of the Exchange based on age, health status, gender or geography, and other factors. If agents, brokers and distributors are permitted to steer individuals to particular Exchange plans to serve their economic interest, they should be required to give prospective customers a large-print notice drafted by HHS, that the customer must sign, which explains that they are not independent, objective navigators, that they receive a fee if the individual signs up for the plan and that there are independent navigators available to help them understand all their options free of charge.

Marketing costs can be reduced by direct sale of plans from the Exchange to small employers. The experience of other Exchanges and pools (COSE, Pac Advantage, CBIA in Connecticut, the Massachusetts Connector) shows that brokers could play a role marketing the Exchange plans as well as plans outside the Exchange, especially for small employers, though this role should be different considering the availability of the Exchange to perform some functions that brokers now provide.

Whether or not brokers, agents or distributors are utilized, a state Exchange should ensure that navigators and public workers are available free-of-charge to perform these functions for both individuals and small employers.

Technology

The efficacy of an information technology system could make or break the new program. Much of the promise of ACA's expansion of health insurance coverage is built on an assumption of highly-sophisticated healthcare information technology systems at both the state and Federal levels. New protocols, standards and systems will be required to match federal and state data electronically to determine and verify eligibility, accept documents, renew coverage, and allow individuals to manage their benefits online.

Certification as QHPs

State premium rate-review efforts historically have been weak. Illinois lacks rate approval or does not have the resources to review the actuarial soundness of health plan submissions. This was a well-documented problem in California this year when an independent actuary found "math errors" that led to vast over-calculation of premiums by Wellpoint's Anthem Blue Cross subsidiary.

Illinois should use the premium review grants to improve the transparency of rate reviews, including public reporting, more detailed review of service-specific expenses and administrative costs, and cost-containment initiatives. The rate-review process should be used to help states enforce other requirements, including the requirement that insurers establish a single risk pool across all plans inside and outside the Exchange. **Illinois must take legislative action to increase their authority to review, approve and recalibrate premium rates.**

The Exchange should examine the following factors to determine whether premium increases are justified:

- Detailed information about the rate change, including:
    - Average rate increase
    - Aggregate increases by benefit category, including doctors, hospitals, prescription drugs, and other services, by geographic area
    - Rate of change over time
    - Changes in copays and deductibles
    - Changes in benefits
    - Changes in rates paid to providers
    - Number of consumers and employers affected by each rate increase
- Adequacy of premium rates for payment of claims
- Rates are reasonable for the benefits offered, based on actuarial analysis
- Rates are not excessive
- Rates are not discriminatory
- Insurer's investment income and surplus
- Insurer's cost containment initiatives
- Insurer's administrative expenses
- Medical-loss ratio, including consumer rebates issued
- Measures of plan quality and consumer satisfaction
- Prior notice of at least sixty days of rate hikes to consumers and businesses
- Rate hikes and justifications to be posted to the website of the insurer and federal and state regulators

## QUALIFIED HEALTH PLANS (QHPS)

Under the ACA, Exchanges are responsible for certifying, recertifying, and decertifying health plans, pursuant to the requirements addressed in statute and subsequent HHS regulation. Illinois should be encouraged to hold plans to even higher standards if they determine it to be in the best interest of consumers.

Certifying, recertifying and decertifying health plans is an activity that requires the exercise of substantial discretion in applying government authority and decision-making. The best way to ensure accountability and transparency is through the use of governmental staff that will carry out these functions without bias and conflicts of interests and in the best interest of the public.

The ACA does not allow, nor should HHS permit, the relaxation of the certification requirements for other forms of Exchanges, i.e., for the SHOP Exchanges, or for regional or subsidiary Exchanges. And HHS should clarify that an Exchange that operates in more than one state must hold plans to higher standards, particularly if stronger state laws already exist.

If Exchanges are to deliver the maximum value for consumers and small employers, states must be encouraged to use an active purchaser model as exemplified in Massachusetts. In Massachusetts, the Connector generates premium saving of approximately 6 percent by negotiating for lower bids in Commonwealth Care. Over the three years of the program, premiums have been constrained, growing only 4.7 percent in Commonwealth Care versus 8 percent in other private insurance. The active-purchaser Exchange could give enrolling individuals and small employers the same type of clout that large employers have when they negotiate with an insurance company on behalf of their workers. While circumstances in the marketplace will strongly affect the outcome of such negotiations or selection process, if Exchanges do not actively pursue the best deal possible for consumers, there is little hope that they will fulfill their potential to deliver high value coverage. While insurers may initially have dominating leverage in negotiations in many areas, over time, this leverage will diminish over time as more plans enter the Exchange market and compete for a large new supply of customers. The Exchanges should be designed to achieve the marketplace we want, not settle for small improvements over the one we have.

Illinois must not allow the Exchange to accept all carriers that meet minimum standards without any negotiation or selection process. If all plans meeting minimum standards are accepted, consumers in many markets will find themselves overwhelmed by a dizzying array of plan options. In such situations, the insurance firms with the most aggressive marketing resources, rather than the highest value plans, will prevail. By way of example, the Commonwealth Connector has recently moved to reduce the number of plans offered in order to eliminate confusion over meaningless differences among plans.

Certification Criteria

The statute requires development of certification criteria on a range of issues. We recommend considering the following factors for each area:

- *Essential community providers*. We applaud the language in the statute that requires plans to include in their network, where available, essential community providers that serve medically underserved and low-income populations. Ensuring that consumers in the Exchanges have access to these providers—including women's health centers, HIV/AIDS clinics, public hospitals, and community health centers—will help ensure continuity of care for recently uninsured patients, as well as those who transition off Medicaid because of income fluctuations.

- *Quality Improvement*. Health plans can play a critical role in improving the quality of care – and should be expected to do so. They can benchmark providers against each other to stimulate improvements, reward high quality care, provide data to understand patterns of care and opportunities for improvement, help patients manage their own conditions, reduce readmissions, reduce health care disparities, and encourage adoption and use of health IT.

HHS should set out clear metrics for the quality improvement strategies outlined in §1311(g)(1). Plans should be held accountable for their results – with clear goals and benchmarks – so that consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time.

- *Use of Standard Forms*. We applaud the certification requirement that plans use a standard benefit format to help consumers and small business owners make informed purchasing decisions. Plans should also provide more detailed information on benefits and coverage through an easily-accessed link on the Exchange website. HHS should consider requiring a standard, consumer-friendly "explanation of benefit" (EOB) form (the form typically received by a consumer after a claim has been filed). These forms often cause confusion. Creating a standard, simplified EOB would help consumers better understand their cost-sharing responsibilities. To avoid confusion about enrollment and people unintentionally signing up for a health plan, as they have been misled into doing by unscrupulous brokers of Medicare Advantage and Medicare supplemental insurance plans, we urge HHS develop a standard enrollment form as well.

- *Quality Information for Enrollees*. The information provided to consumers on plan quality measures must be relevant, digestible and actionable for them to make informed purchasing decisions. Providing a laundry list of performance measures is not as valuable for consumers. Most will want some form of composite rating, and there should be a clear and simple explanation of how the measures were determined. HHS should require plans to provide "layers" of information through a web-based interface, so that consumers seeking more detailed information about performance on specific quality and consumer experience measures can access it. And consumers will need to be able to make apples-to-apples comparisons among health plans.

To the extent possible, all certification criteria should be echoed in regulation of the insurance market outside the Exchange. Without identical requirements inside and outside the Exchange, adverse selection is likely. Some particularly important factors suggested below should apply not only for certification of QHPs but for all health plans operating in the state.

- *Marketing standards*: Plans will likely use marketing tools to the extent they are able to encourage the healthiest people to enroll while discouraging those with unhealthy risks. Plans' behavior in the marketplace, as well as the behavior of their agents and brokers, needs to be continually monitored and the marketing standards may need to be tightened over time.

- *Network adequacy*: Plans should demonstrate that they have a reasonable choice of providers in a reasonable geographic proximity who are taking new patients. In particular, we urge that federal standards prohibit plans from designing networks that will keep out high-cost patients. Regulators should prohibit plans from designing networks that are dominated by physicians and providers in suburban areas while excluding physicians and other providers who are located in lower-income urban areas. Plans should be encouraged to include Medicaid providers to facilitate continuity of care for families transitioning off of Medicaid eligibility or who shift back and forth between Medicaid and Exchange coverage. In addition, we applaud the requirement in the California legislation, AB 1602, which requires carriers to regularly update an electronic directory of contracting providers. This

will enable individuals and small businesses to search by health care provider name and see which plans include the provider in their network and to ascertain whether the provider is accepting new patients for a particular health plan.

As you consider minimum marketing standards, Illinois should be encouraged to set the same standards for plans operating inside and outside the Exchange. Allowing plans operating solely outside the Exchanges to follow less stringent marketing and benefit design standards could set up an unlevel playing field, allowing these plans to use marketing tactics to cherry pick the healthiest risks and discourage sicker individuals. And all plans, whether or not they participate in the Exchange, should be subject to the same market conduct reviews.

In addition, we encourage you to include the following requirements in the marketing standards for plans:

- Health plans should be required to provide standardized information to prospective and new enrollees, including:
  - Information on benefits, limitations, exclusions, restrictions on use of services, and plan ownership;
  - A summary of physicians' financial incentives, written in terms that the average consumer can understand;
  - The stability and composition of the provider and practitioner network, including participating physicians, hospitals and pharmacies. The list should indicate whether the provider or practitioner is accepting new patients covered by the plan, language capacity, hours of operation, and disability accommodation. There should be a "map view" option that shows the location of providers relative to public transportation;
  - Comparative information that is standardized on patients' experience with care in the plan and, to the extent possible, the plan's clinical performance, along with comprehensive information reflecting standardized metrics to compare the performance of participating physicians and other health professionals, hospitals, post-acute care facilities, and home health agencies;
  - Comparative information on out-of-pocket costs for patients with different health conditions;
  - Accreditation information;
  - Disenrollment experience;
  - Data on grievances and appeals filed by enrollees; and
  - The plan's current status with respect to compliance with statutory and regulatory requirements.
- All marketing materials should be approved by the Exchange and/or the state before their use, written at a sixth-grade reading level or lower, and available in languages other than English when the plan serves or will serve substantial numbers of enrollees whose native language is not English.[1]

[1] Many, if not all, Exchange-participating plans will be receiving federal financial assistance, including credits, subsidies, or contracts of insurance, and thus will be subject to Section 1557 of t he ACA which prohibits discrimination on the bases set forth in Title VI and the Rehabilitation Act, among other statutes. These Acts, in turn, have been interpreted to require the services provided by federal grantees and the federal government meet

- To avoid the possibility of discrimination against population groups based on place of residence, participating plans should be required to serve a complete market area (i.e., they should not be allowed to "gerrymander" their market area).

State regulators should also monitor and regulate the conduct of insurance agents and brokers with uniform standards inside and outside the Exchange. The following activities should be prohibited:

- Door-to-door solicitation
- Offering potential consumers financial or other inducements to enroll
- Discriminatory activities designed to discourage sicker-than-average enrollees and encourage healthier-than-average enrollees.
- Allowing someone to sign a piece of paper that enrolls them in a plan without giving them a standardized, easy-to-read paper that they sign and keep a copy of explaining that by signing they are agreeing to enroll in a particular plan and that plans available through the Exchange will offer a subsidy to people with low and moderate incomes.

Marketplace Rules

We recognize that Illinois has little or no competition in their individual and small group markets among health plans, and we will face unique challenges in trying to attract and retain a sufficient mix of qualified health plans within the Exchange. However, we believe that, over the long term, if states design their Exchanges first and foremost to benefit consumers, so that they are attractive, consumer-friendly marketplaces in which consumers can be assured of adequate, affordable coverage, a sufficient mix of health insurance carriers will follow.

To achieve this, however, it will be critical for states to make the market rules inside and outside the Exchanges the same, so there is a "level playing field" and all plans in the state are required to meet the same certification standards. States that do not do this and allow the market outside the Exchange to operate under substantively different rules will have a difficult time attracting a healthy mix of insurance carriers to the Exchange. This also raises the risk of adverse selection, which could drive up premium costs for Exchange enrollees.

The requirements for risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the Exchanges, are critical tools to limit adverse selection and encourage plans to participate in the Exchange. However, these tools will not be sufficient if states do not apply the same rules to plans inside and outside the Exchange. HHS should use grant support and technical assistance to help states enact the laws and rules necessary to mitigate adverse selection between the Exchange and non-Exchange markets.

Standards for participation in an Exchange must advance a legitimate policy goal and not be designed to inappropriately advantage a particular carrier. For example, in a state dominated by

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certain standards in order to be Title VI and Rehabilitation Act compliant. These plans should follow HHS guidance regarding Title VI's prohibition against national origin discrimination affecting limited English proficient persons (68 FR 47311), and use the four-factor analysis to determine the extent of their obligation to provide LEP services.

one or two carriers, a rule requiring state plans to operate statewide may exclude high-value integrated systems that serve only one region of the state.

Enrollment and Eligibility

In the first year, federal guidance should allow for greater flexibility for individuals enrolling in the Exchange so that families have time to learn about the options available to them under the new law and enroll in the plan that best meets their needs. Specifically, guidance should allow for a longer duration open enrollment period prior to January 1, 2014, and ensure that families can enroll at least six months past the January 1, 2014, implementation date in order to take advantage of the publicity and greater public awareness of the availability of Exchange coverage and the coverage requirement.

In subsequent years, guidance should ensure that open enrollment periods are available to families at least once a year during a standardized time period (such as September through early December, which would allow Exchanges to make necessary eligibility determinations and health plans to enroll families for the plan year starting on January 1, 2014, and generally lines up with the open enrollment periods for employer-sponsored insurance). The guidance should also call for the period(s) to last at least 90 days and for insurers to fully advertise the availability of coverage during these open enrollment periods. In addition, the law should follow HIPAA and Medicare guidelines in establishing qualifying events that will trigger special enrollment periods for subscribers and dependents into both subsidized and unsubsidized coverage in the Exchanges, including:

- Changes in family circumstances, such as marital status and change in number of dependents
- Aging out of dependent or child-only coverage
- Birth of child or adoption
- Loss of other public or private coverage
- Employment status change, including termination of employment, change from part-time to full-time status, or vise versa, change in employment status that affects dependent coverage
- Change of residence
- Coverage mandated as a result of a court order

Small businesses should be allowed to purchase coverage through the Exchange generally at any time (which for currently insured employers would be the end of their current plan year, and for those newly offering coverage, whenever they arrange for such coverage). Employees of the small business would still have open enrollment periods but those periods would depend on when the plan was initially purchased – as it works today in the small group market.

The enrollment design should ensure that individuals never fall into coverage gaps. It should also ensure that the consumer and state Exchange know exactly what plan the individual is enrolled in from the moment they sign up for a plan. And there should be provisions in place for changing plans during the open enrollment period.

Outreach and Enrollment

The most successful outreach strategies will include utilizing community-based groups and application assistors; working through schools, churches, and labor unions; creating trusted messengers; and developing effective media strategies (such as working with ethnic media). Particular efforts should be made to engage medical professionals, offices, hospitals and clinics in outreach. For small businesses, effective strategies will include utilizing trusted messengers, and providing employers with comprehensive information on the availability of coverage and what the ACA means to them (including small business credits, explanation of grandfather plans, and how the Exchanges work). Outreach strategies should also be data-driven. Data can help to identify groups to best target for outreach. Segmenting target audiences allows messages to be tailored to better resonate with those audiences.

Other public programs will be critical "connectors" to the Exchange and Medicaid/CHIP coverage. As much as possible, linkages with other public programs should be automatic. For example, when someone applies for unemployment insurance the system should trigger a review of their eligibility for subsidies or public programs. When a child or adult is enrolled in Free School Lunch or SNAP, there should be automatic or expedited routes to coverage. For example, millions of childless adults who will be newly eligible for Medicaid in 2014 are already enrolled in SNAP and eligibility information for SNAP could thus be used to enroll them in Medicaid once the Medicaid expansion takes effect.

Information that consumers will find useful from Exchanges in making plan selections

Consumers need clear, accurate, and easily understood information about their health insurance options. Special care should be given to ensure information is understandable to low-income populations that may have little experience purchasing traditional insurance products and to low literacy populations.

To facilitate consumer choice, an Exchange website must present information in a manner that allows consumers to make meaningful comparisons of their health coverage options. Consumers should be able to narrow the list of options to a few select plans to make more detailed, head-to-head comparisons of health plan features, including premiums, cost sharing, benefits and benefit limits, provider networks, formularies and pharmacy benefits, and quality metrics and accreditation status. They should also have the ability to search for a particular doctor or hospital.

Also, the Exchanges should provide consumers with information about how the health insurance system operates in Illinois. Consumers need information about when, how, and under what circumstances they can switch between plans, along with information on shifting eligibility between Medicaid, CHIP, and private coverage. They should also be informed of relevant state laws, including laws mandating benefit coverage beyond the essential benefits package and laws restricting or banning coverage (e.g., abortion coverage), and consumer protections (e.g., bans on pre-existing condition exclusions, appeals rights, rights and protections regarding out-of-network billing and debt collection practices, etc.).

Determining whether or not to enroll in an Exchange

When considering health insurance options, consumers need readily accessible and clearly presented information on plans available to them, including premiums, cost sharing, benefits (including non-dollar benefit limits), network, and formulary information.

Consumers should be informed of enrollment windows and whether they qualify for subsidies (both premium tax credits and cost-sharing reductions) or public insurance. Information on which consumer protections apply to plans both inside and outside the Exchanges and the requirements qualified health plans must meet will also be important for consumers as they decide on coverage and should be presented in simple language and format, such as in a chart format.

Before the Exchanges are operational, it is critical consumers have information about subsidies in the Exchange and the new tax implications. This information could be conveyed through commercial and volunteer tax preparers and software, the Internal Revenue Service, employers and others with tax knowledge, and federal and state websites, and should be provided beginning in the tax year 2012 filing season.

To be most effective, efforts to convey accurate and individualized information to consumers should take many different forms. Enrollment activity should be preceded by a highly visible and sustained media campaign - including television, radio, print, and social media – to raise the public's awareness of the Exchanges.

The Exchanges must operate pursuant to §1557 of ACA, which prohibits discrimination on the bases set forth in Title VI and the Rehabilitation Act, among other statutes. In addition to complying with these legal requirements, Exchanges should take steps to ensure they are accessible to diverse populations. Information on Exchange websites should be available in multiple languages and be culturally sensitive and linguistically appropriate. The Exchange's toll-free telephone hotline should be clearly displayed on the website and at highly visible places in the community, such as on public transportation. Telephone operators who speak a variety of languages should be available to refer consumers to local resources.

Community health, education and outreach workers with existing relationships in culturally-diverse communities should be incorporated into Exchange outreach efforts. Outreach efforts should consider how to reach people who are homebound or who cannot travel to a state office and a mail campaign should be employed. States and other entities will need sufficient time and funding to train outreach workers and counselors to serve as resources to consumers in the Exchanges and establish effective outreach to culturally-diverse populations.

Consumer Complaints

Exchanges and navigators should be required to notify all consumers in easy-to-understand language that they have access to both a complaint and appeal process, and how those processes can be triggered. Any deadlines should be reasonable and clearly articulated to consumers. Consumers should have the right to request reconsideration of an initial decision.

Complaints and appeals could stem from Exchange-related actions and decisions (e.g., denial of a premium tax credit or denial of a hardship exemption from the coverage mandate) or insurance company misbehavior within the Exchange.

State Exchange complaint and appeal data should be provided monthly in a uniform standardized format to federal regulators for national data compilation and analysis. If a state has more than one Exchange, data should be consolidated for state use and forwarded to federal regulators.